DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 day 10/10/10

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

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F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #'s 24563, 24766, 25880, were completed on August 24-26, 2010, at Mt. Juliet Health Care Center. No deficiencies were cited in relation to the complaint investigation #'s 24563, 24766, and 25880, under 42 CFR Part 483.13, Requirements for Long Term Care Facilities.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to promote care in a manner and in an environment that maintained or enhanced each resident's dignity for four residents (#14, #16, #17, #21) of twenty-three residents reviewed. The findings included: Observation on August 25, 2010, at 8:15 a.m. through 8:30 a.m., revealed Certified Nurse Assistant (CNA) #2 standing while feeding residents #14, #16, #17, and #21 in the dining room. Interview with the Director of Nursing (DON) in the dining room during the observation on August 25, 2010, at 8:30 a.m., confirmed CNA #2 standing and feeding the residents was not a manner and an environment that enhanced dignity for residents while eating.	F 241	F241 483.15(a) Dignity and Respect of Individuality SS=E Requirement: The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action: 1. The Certified Nursing Assistant was instructed immediately by DON at time of observation on proper feeding position to promote dignity. 2. All residents that require total assistance with meals will be assisted with C.N.A./staff maintaining correct positioning at eye level to promote dignity and respect. 3. Educate all nursing staff regarding proper feeding for total assist residents. 4. Dining room practices will be monitored weekly by DON/ADON or designee. Review of mealtime will be discussed with QA Committee.	9/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Francis Doyle — Administrator — 9-8-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders for two residents (#15, #20) of twenty-three residents reviewed. The findings included: Resident #15 was admitted to the facility on July 21, 2010, with diagnoses including Gastroesophageal Reflux Disease, Cerebrovascular Accident, Peripheral Vascular Disease, and Hyperlipidemia. Medical record review of the August 2010, physician's recapitulation orders revealed the resident was to receive Ranitidine (anti-ulcer medication) 150 mg (milligrams) twice a day. Medical record review of the August 2010, Routine Medications record revealed the Ranitidine 150 mg was administered once daily August 1-24, 2010. Interview on August 25, 2010, at 8:10 a.m., with the Director of Nursing, at the nursing station, confirmed the Ranitidine150 mg was not administered twice a day from August 1-24, 2010, and confirmed the physician's orders were not followed. Resident #20 was admitted to the facility on	F 281	F281 483.20 (K)(3)(i) SS=D Requirement: The service provided or arranged by the facility will meet professional standards of quality. Corrective Action: 1. Resident # 15's MD was notified on 8/25/10 of medication transcription and omission error. New order received to change Ranitidine 150 mg from BID to QD. Resident #20 discharged from facility on 11/30/09. 2. All resident's MARS will be reconciled with current MD orders to ensure proper administration practices by DON/ADON or designee. 3. Two Nurses are to sign monthly orders to ensure accuracy and completion with reconciliation. Staff education on correct procedure on end of month reconciliation with past orders, MAR, new month MD orders. 4. Weekly audit (25% sample) will be conducted by Risk Management Nurse or designee for safe administration practices to ensure MD orders and MARS are correctly reconciled. Audits will be reviewed in monthly pharmacy meeting and areas of non compliance will be corrected per facility protocol and reviewed in quarterly QA.	8/25/10 9/9/10 9/10/10

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F 281	Continued From page 2 November 25, 2009, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, and Senile Dementia. Medical record review revealed the resident was discharged home on November 30, 2009. Medical record review of the physician's orders dated November 25, 2009, revealed the resident was to receive Lasix (diuretic) 10 mg every other day. Medical record review of the November 25-30, 2009, Medication Record revealed the resident received the Lasix 10 mg on November 27-30, 2009, (daily for four days). Interview on August 26, 2010, at 1:00 p.m., with the Director of Nursing, in the conference room, confirmed the Lasix 10 mg was administered daily from November 27-30, 2009, and confirmed the physician's orders were not followed.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement the care plan for two residents (#6, #9) of twenty-three residents reviewed. The findings included:	F 282	**F282 483.20 (K)(3)(ii) Services by qualified persons / per care plan SS=D** **Requirement:** The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. **Corrective Action:** 1. Resident #6 is receiving sandwich with lunch and dinner tray daily. Resident #9's TED hose d/c due to non-compliance. Gerisleeves to bilateral upper extremities and bilateral lower extremities in place per plan of care. Non-skid socks in place.	9/8/10

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F 282	Continued From page 3 Resident #6 was admitted to the facility on March 12, 2005, with diagnoses including End Stage Dementia, Chronic Obstructive Pulmonary Disease, Anxiety, and Hypertension. Medical record review revealed the resident began receiving hospice services on February 12, 2010. Medical record review of the Plan of Care dated June 18, 2010, revealed "...risk for weight loss...mech (mechanical) soft diet add sandwich to meals & other finger foods..." Observation on August 24, 2010, from 12:22 p.m., until 12:40 p.m., revealed the resident seated in a wheelchair, at a table in the small dining room. Continued observation revealed there was no sandwich on the resident's tray and the resident was feeding self sweet potatoes and chopped ham with the fingers. Observation on August 25, 2010, at 12:35 p.m., revealed the resident seated in a wheelchair, at a table in the small dining room. Continued observation revealed there was no sandwich on the resident's tray, and the resident was feeding self spinach with cheese, chopped beef, fried potatoes, and chocolate pie with the fingers. Observation and interview on August 25, 2010, at 12:40 p.m., with the Assistant Director of Nursing, revealed the resident feeding self pie with the fingers, and confirmed there was no sandwich or other finger foods provided with the lunch meal and the Plan of Care was not followed. Resident #9 was admitted to the facility on October 27, 2008, with diagnoses including Dementia, Neurotic Disorder, Anxiety, and History of Fractured Femur (long bone in leg).	F 282	2. Care Plan audit for all residents to ensure interventions are in place. Corrections will be made by DON/ADON. 9/9/10 3. Nursing staff in-serviced on following plan of care and diet sheets to ensure resident's needs are being met and plan of care is followed. Audits performed weekly by risk management nurse or designee. 9/9/10 4. Weekly audit X 2 months or until 100% compliance by risk management nurse or designee for compliance and review in monthly QA meeting with interdisciplinary team to monitor for effectiveness.	

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F 282	Continued From page 4	F 282		

Medical record review of the Minimum Data Set dated July 2, 2010, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living.

Medical record review of the nurse's notes dated May 1, 2010, to August 26, 2010, revealed the resident had frequent skin tears to the arms and legs, including a skin tear on the right leg that required stitches on May 18, 2010.

Medical record review of the resident's current care plan revised on July 7, 2010, revealed "...TED hose (support stockings) when up in w/c (wheel chair) with gripper socks as tolerated...geri sleeves (cotton sleeves to decrease skin tears) to BUE (both upper extremities) BLE (both lower extremities) as tolerates. Encourage (resident) to wear geri sleeves. Encourage protective sleeves to upper and lower extremities at all times as (resident) tolerates while in and out of bed...apply non-skid socks when shoes are removed..."

Observation with Licensed Practical Nurse (LPN) #1 on August 26, 2010, at 9:46 a.m., in the resident's room revealed the resident sitting in the wheel chair with regular socks (not non-skid), no geri sleeves on the arms or legs, and no TED hose applied. Interview with LPN #1 confirmed the resident's care plan was not implemented.

Observation and interview on August 26, 2010, at 9:55 a.m., with Certified Nurse Assistant (CNA) #1 in the resident's room revealed no geri sleeves or non-skid socks in the resident's room, and the TED hose were in a drawer. Interview with CNA #2 confirmed the resident's care plan was not

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F 282	Continued From page 5 implemented.	F 282		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to label and date a tube feeding formula for one resident (#4) of twenty-three residents reviewed. The findings included: Resident #4 was admitted the facility on July 15, 2008, with diagnoses including Cardiovascular Accident (Stroke), Dysphagia, and Percutaneous Endoscopic Gastrostomy Tube (PEG Tube - a tube placed in the stomach as a means of feeding when unable to eat). Medical record review of the August 2010, Physician's Recapitulation Orders revealed, "Jevity 1.2 Cal at 60 ml (milliliters) per hour..." Observation on August 25, 2010, at 7:35 a.m., revealed a 1000 ml bottle of Jevity 1.2 Cal hanging and infusing via pump. Continued observation revealed the label on the bottle of the	F 322	**F322 483.25 (g)(2) No Treatment / Services-Restore Eating Skills SS=D** **Requirement:** The facility will ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services. **Corrective Action:** 1. Resident #4's tube feeding formula was removed immediately on 8-25-10 at 7:35 a.m. by licensed nurse. A new bottle of formula was labeled and dated per MD order. 8/25/10 2. All residents with orders for enteral support will have tube feeding formula labeled per facility protocol and standards of practice. 9/9/10 3. Education for licensed nurses RE: facility protocol and standards of practice for correct labeling of tube feeding products prior to administration. 9/9/10 4. DON/ADON/Risk Management Nurse will make daily rounds on environment and monitor for proper labeling of tube feeding formula. Non-compliance will be corrected immediately and 1:1 education will be given. During daily QA meeting, findings will be communicated to interdisciplinary team members.	

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F 322	Continued From page 6 Jevity 1.2 Cal was blank and did not include the rate per hour, date, resident's name and the initials of the nurse. Review of the facility's Enteral Tube Management/Medication Administration guidelines dated January 2005, revealed, "...The tube feeding...will be property labeled with type of formula, rate per hour, date, patients name and the initials of the nurse...This applies to any tube feeding whether by NG tube, peg/gastrostomy tube..." Interview with Licensed Practical Nurse (LPN) #3 on August 25, 2010, at 7:45 a.m., in the resident's room, confirmed the facility failed to label the bottle of Jevity 1.2 Cal according to facility policy and procedure.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place or functional for two residents (#14, #12) of twenty-three residents reviewed. The findings included:	F 323	**F323 483.25 (H) Free of accident hazards / supervision / devices** **SS=D** **Requirement:** The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **Corrective Action:** 1. Resident #14's personal clip alarm was discontinued on 8-9-10. Wheelchair sensor pad was placed on 8-9-10. Resident #12's wheelchair alarming device has been discontinued per MD order. 8-9-10 2. Residents in the facility have been re-assessed by the licensed nurses for high risk of falls. If identified 9-8-10	

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F 323	Continued From page 7 Resident #14 was admitted to the facility on June 7, 2010, with diagnoses including Alzheimer's Disease, Osteoporosis, and Hyperlipidemia. Medical record review of the Minimum Data Set (MDS) dated June 17, 2010, revealed the resident had severely impaired cognitive skills and required extensive assistance with transfers. Medical record review of the Fall Risk Assessment dated July 6, 2010, revealed the resident was at high risk for falls. Medical record review of the Plan of Care dated June 22, 2010, revealed the resident was at risk for falls and a personal body alarm was to be used. Medical record review of a nursing note dated August 9, 2010, at 11:00 a.m., revealed the resident was found lying in front of the wheelchair and the personal body alarm was not in place. Continued review of the nursing note revealed the resident did not experience any injury related to the fall. Observation on August 25, 2010, at 3:15 p.m., revealed the resident lying on a low bed, with a fall mat and a pressure sensitive alarm in place. Interview on August 25, 2010, at 8:05 a.m., with the Director of Nursing (DON), in the conference room, revealed the DON had investigated the resident's fall on August 25, 2010, and confirmed the personal body alarm was not in place at the time of the fall on August 25, 2010. Resident #12 was admitted to the facility on December 12, 2007, with diagnoses including	F 323	as a risk for fall, fall prevention measures have been put in place, including but not limited to low bed, mat on floor, call light within reach, personal clip alarm, wheelchair alarm or bed alarm per MD order. Residents admitted to the facility will be assessed for high risk of falls upon admission by a licensed nurse. Measures to prevent falls will be implemented after obtaining an MD order and will be reflected on the plan of care. 9/9/10 3. Weekly IDT meeting will be held to ensure that applicable preventative measure are in place and plans of care are updated as needed. Nursing staff and facility staff will be in-serviced on the use of fall prevention measure for residents identified as a risk for falls. 9-9-10 4. The DON/ADON will be responsible for corrections. Random checks will be done during clinical rounds by DON/ADON/Risk management Nurse and Staff Development Nurse to ensure that measures to prevent falls are implemented as ordered by MD. Any negative findings will be reported to DON for correction and for on-going QA review at Quarterly QA meeting.	

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F 323	Continued From page 8 Senile Dementia with Delusional Features, History of Stroke, and Macular Degeneration (affects the eyesight). Medical record review of the Minimum Data Set dated July 1, 2010, revealed the resident had impaired short term memory, impaired decision making skills, required assistance with all activities of daily living including transfers, and the resident had fallen in the past 31-180 days. Medical record review of the August 2010, physician's recapitulation orders revealed "...chair and w/c sensor alarm..." Observation on August 24, 2010, at 3:00 p.m., in the hallway just outside of the dining room, revealed the resident stood from the wheel chair and no alarm sounded. Observation and interview on August 25, 2010, at 12:35 p.m., with Licensed Practical Nurse (LPN) #2 and Housekeeper (HSK) #2 in the resident's room, near the hallway door revealed the resident standing behind the wheel chair, with no alarm sounding. Interview with LPN #2 and HSK #2 revealed the resident "...turns the alarm off all the time...". Continued interview confirmed the resident's alarm was not sounding to alert staff of an unsafe transfer.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	**F514 483.75 (i)(1) Resident records are complete / accurate / accessible** **SS=D** **Requirement:** The facility will maintain clinical records on each resident in accordance with accepted professional standards and practice that are complete; accurately documented, readily accessible; and systematically organized.	

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F 514	Continued From page 9 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete medical record for one resident (#19) of twenty-three residents reviewed. The findings included: Resident #19 was admitted to the facility on August 17, 2009, with diagnoses including Failure to Thrive, Organic Brain Syndrome (dementia), and Debility. Medical record review of a physician's order dated February 23, 2010, revealed the resident was sent to the emergency room. Medical record review of the nurse's notes dated February 23, 2010, (no further notes after that time/date) revealed the resident was sent to the emergency room but did not indicate if the resident would return to the facility or had been discharged from the facility. Medical record review of the social service notes revealed the last note was dated February 6, 2010. Continued review revealed no notation the resident was sent to the emergency room on February 23, 2010, and if the resident would	F 514	Corrective Action: 1. Resident #19 has been discharged from the facility. Discharge audit was completed and missing items completed for closed record. 2. 100% of discharged charts will be reviewed for completeness to include final disposition note for social services and nursing, discharge summary, physician's orders and interdisciplinary progress notes. 3. Education will be given to interdisciplinary team regarding disposition of closed charts and disciplinary note completion. 4. Medical records to audit ongoing all discharged charts for compliance with disciplinary notes upon discharge. Administrator will monitor and review for compliance in monthly QA meeting and quarterly QA with the medical director.	9-9-10 9-9-10

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F 514	Continued From page 10 return to the facility or if the resident was discharged from the facility. Interview on August 26, 2010, at 11:00 a.m., in the conference room with the social services director confirmed the resident did not return to the facility when discharged from the hospital, was discharged from the facility on February 23, 2010, and the resident's medical record was not complete.	F 514		